

<p><u>For office use only:</u></p> <p>Date of Admission: ____/____/____</p>

Discover Preschool

Child's Enrollment Form

Child Information

Child's Name: _____ Date of Birth: _____

Age at Admission: _____ Date of Admission: _____

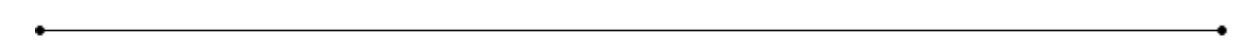
Child's Home Address: _____

Home Phone Number: _____

Primary Language: _____ Identifying Marks: _____

Eye Color: _____ Hair Color: _____ Skin Color: _____

Sex: _____ Height: _____ Weight: _____



Parent/Guardian Information

Parent/Guardian Name: _____

Relationship to Child: _____

Home Address: _____

Reachable Phone Number: _____

Email Address: _____

Business Name: _____

Business Address: _____

Business Phone Number: _____

Hours at Work: _____

Parent/Guardian Name: _____

Relationship to Child: _____

Home Address: _____

Reachable Phone Number: _____

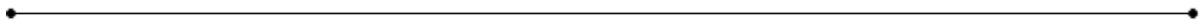
Email Address: _____

Business Name: _____

Business Address: _____

Business Phone Number: _____

Hours at Work: _____



Additional Information

Child's Physician: _____

Address: _____ Phone Number: _____

Allergies/Special Diets? _____

Individual Health Plan for child with a chronic health condition? If yes, please attach. _____

Copies of any custody agreements, court orders, and restraining orders pertaining to the child?
If yes, please attach. _____

Special limitations or concerns? _____

Parent/Guardian Signature

Date

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

Discover Preschool

DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION

Regulations for licensed child care facilities require this information to be on file to address the needs of children while in care.

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

Please provide information for Infants and Toddlers (marked *) as appropriate to the age of your child.

DEVELOPMENTAL HISTORY

Age began sitting: _____ crawling: _____ walking: _____ talking: _____

*Does your child pull up? _____ *Crawl? _____ *Walk with support? _____

Any speech difficulties? _____

Special words to describe needs _____

Language spoken at home _____ *Any history of colic? _____

*Does your child use pacifier or suck thumb? _____ *When? _____

*Does your child have a fussytime? _____ *When? _____

*How do you handle this time? _____

HEALTH

Any known complications at birth? _____

Serious illnesses and/or hospitalizations: _____

Special physical conditions, disabilities: _____

Allergies i.e. asthma, hay fever, insect bites, medicine, food reactions: _____

Regular medications: _____

EATING HABITS

Special characteristics or difficulties: _____

*If infant is on a special formula, describe its preparation in detail: _____

Favorite foods: _____

Foods refused: _____

* Is your child fed held in lap? _____ High chair? _____

* Does your child eat with spoon? _____ Fork? _____ Hands? _____

TOILET HABITS

*Are disposable or cloth diapers used? _____ *Is there a frequent occurrence of diaper rash? _____

*Do you use: oil: _____ powder: _____ lotion: _____ other: _____

*Are bowel movements regular? _____ How many per day? _____

*Is there a problem with diarrhea? _____ Constipation? _____

*Has toilettraining been attempted? _____

*Please describe any particular procedure to be used for your child at the center: _____

*What is used at home? Pottychair? _____ Special child seat? _____ Regular seat? _____

*How does your child indicate bathroom needs (include special words): _____

Is your child ever reluctant to use the bathroom? _____

Does your child have accidents? _____

SLEEPING HABITS

*Does your child sleep in a crib? _____ Bed? _____

Does your child become tired or nap during the day (include when and how long)? _____

Please note: The American Academy of Pediatrics has determined that placing a baby on his/her back to sleep reduces the risk of Sudden Infant Death Syndrome (SIDS). SIDS is the sudden and unexplained death of a baby under one year of age. If your child does not usually sleep on his/her back, please contact your pediatrician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss your child's sleeping position with your caregiver.

When does your child go to bed at night? _____ and get up in the morning? _____

Describe any special characteristics or needs (stuffed animal, story, mood on waking etc) _____

SOCIAL RELATIONSHIPS

How would you describe your child? _____

Previous experience with other children/day care: _____

Reaction to strangers: _____ Able to play alone? _____

Favorite toys and activities: _____

Fears (the dark, animals, etc.): _____

How do you comfort your child? _____

What is the method of behavior management/discipline at home? _____

What would you like your child to gain from this childcare experience? _____

DAILY SCHEDULE

Please describe your child's schedule on a typical day. For infants, please include awakening, eating, time out of crib/bed, napping, toilet habits, fussy time, night bedtime, etc. _____

Is there anything else we should know about your child? _____

(Parent/Guardian Signature)

(Date)

DISCOVER PRESCHOOL PERMISSIONS FORM

Consent for Observation of Child:

I hereby grant permission for my child _____ to be observed by any person visiting the Discover Preschool grounds that is under the direction and guidance of the school. My child's name will not be used without specific consent.

Parent Signature _____ Date _____

Consent for Publicity:

I hereby grant permission to release my child's picture and name for purpose of publicity or fundraising.

_____ (Initials) Photos (for Discover Preschool use ONLY within the program, ie. Weekly newsletters)

_____ (Initials) Photos (for Discover Preschool use of release to newspapers or on the Internet, i.e. School website and Facebook page)

Parent Signature _____ Date _____

Discover Preschool Directory Authorization

The Discover Preschool directory will contain the names, addresses, telephone numbers, email addresses, and parents' names of all the students in the class whose families wish to participate. Once compiled, a copy of the directory will be distributed to each family. All parents should complete the bottom portion of this form indicating their wishes concerning the directory. Please return it to the Director prior to the first week of school so we may expedite the directory's distribution in the fall.



PLEASE CHECK YES OR NO

YES, please include my child, in the Discover Preschool Directory. You have my permission to print the following information:

Child's name: _____

Home phone: _____

Address: _____

Email: _____

Parents' names: _____

NO, please do not include my child in the Discover Preschool Directory.

Parent Signature _____

Discover Preschool Emergency Texts

Dear Preschool Families,

It is necessary for the Preschool and Pre-K classes (as well as Early Drop Off and Stay & Play attendees), to be contacted in the event that Discover Preschool experiences a delayed opening, an unexpected early dismissal, or is unable to open for the entire day. These situations may be the result of a power outage, lack of heat, or other unplanned circumstances. Contacting each family will **NOT** be used for snow days, which will be communicated through the standard notification process associated with Andover Public Schools.

In the past, phone calls have been made by a number of preschool parents to everyone on their designated list. However, we have moved towards a group text message that will be originated from either the Parent Board secretary's or the Preschool Director's personal cell phones.

It is important that we have the cell phone number(s) for the family member(s) who is (are) most likely to be available to respond to our announcement.

Again, this group text announcement will only be used in the event of an emergency closure or cancellation at Discover.

Please note, we will continue to adhere to the Andover Public School inclement weather closing and delays that are part of our inclement weather policy.

Child's Name: _____

Name of cell
phone holder(s): _____

Cell phone
number(s): _____

Thank you for your attention to this important matter. Your timely submittal of this information will be greatly appreciated.



Hand Sanitizer Permission Form

Child's name: _____

- I give Discover Preschool permission to use hand sanitizer on my child's hands.
- I do NOT give Discover Preschool permission to use hand sanitizer on my child's hands.

Hand Sanitizer will be stored out of reach of all children.

Teachers will always assist children with hand sanitizer.

Please do NOT send hand sanitizer in or attached to your child's backpack or jacket.

Parent Signature _____ Date _____

Discover Preschool

Stay and Play Oral Health Non-Participation Form

In January 2010, EEC issued new regulations for child care programs that include a requirement that educators assist children with brushing their teeth if children are in care for more than four hours or if children have a meal while in care [606 CMR 7.11(11)(d)]. This regulation is intended to:

- Help children learn about the importance of good oral health
- Provide information and resources regarding good oral health to child care programs and families
- Help address the high incidence of tooth decay among young children in Massachusetts, which is associated with numerous health risks.

Discover Preschool must comply with this regulation during Stay and Play. However, parents may choose that their child(ren) not participate in tooth brushing while at Stay and Play.

You do not need to fill out this form to have your child(ren) participate in tooth brushing while at Stay and Play. However, if you do not want your child to brush his or her teeth while s/he is attending Stay and Play, please fill out the information found below. A separate form must be filled out for each child in care. This form must be renewed annually and will be kept in your child's record at the program. Should you change your mind and wish for your child to participate in tooth brushing, this form may be withdrawn at any time by requesting in writing that it be removed from your child's file. Thank you.

I do NOT wish to have my child participate in tooth brushing

while in care at DISCOVER PRESCHOOL.

Child's Name: _____

Parent/Guardian's Name: _____

Signature: _____

Date: _____

If you have any questions or concerns, please contact the Preschool at 978-475-9706 or at DISCOVERPRESCHOOL@VERIZON.NET.

Discover Preschool Child Medical Alert Form

If your child has an allergy/medical condition, please fill out this form. You must provide a copy of your child's most recent physical form. Also, a Medical Action Plan if your child has a medical condition.

Child's Name: _____

Allergy/Medical Condition _____

In helping us appropriately and safely deal with a situation involving your child in this concern, please complete the following:

1. How do you normally handle this concern?
2. How would you like us to respond if this concern arises?
3. Is there anything that triggers or complicates this situation?
4. Is there anything that your child should avoid doing?
5. What is it? Are there any medical limitations that we should be aware of?
6. Are there things that you find can make the situation worse?
7. Are there things that you find can make the situation better?
8. Are there any non-emergency situations that you would prefer to be phoned by a staff member about to alert you to a given situation?

Signature of Parent/Guardian: _____

Date: _____



Please have your child's pediatrician fill out the following two pages.

OR

Print a copy of your child's immunizations and their most recent annual physical report.
The physical must have been done within the last 12 months.

*** Children may NOT start school without a current physical on file. ***



*** Children with severe allergies may NOT start school without submitting the following:

- Child's medications (ie. EpiPens, Benadryl, inhalers)

All prescription medications must be in the containers in which they were originally dispensed and with their original labels affixed. Over-the-counter medications must be in the original manufacturer's packaging.

- Medication Consent Forms for each medication
- EEC Individual Health Care Plan Form

PLEASE LET ME KNOW IF YOU NEED THESE FORMS FOR YOUR CHILD.

Massachusetts Department of Public Health
CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: / /

Sex: female

male If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib,

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type	
Hepatitis B etc.) (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		Haemophilus influenzae type b (e.g., Hib, HepB-Hib, DTaP-Hib)	1		
	2			2		
	3			3		
		4				
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1		Measles, Mumps, Rubella (MMR)	1		
	2			2		
	3		Varicella (Var)	1		
	4			2		
	5			Hepatitis A (HepA)	1	
	6				2	
7						
Polio (e.g., IPV, DTaP-HepB-IPV)	1		Pneumococcal Polysaccharide (PPV23)	1		
	2			2		
	3		Influenza Inactivated (Intramuscular) or Live (Intranasal)	1		
	4			2		
Pneumococcal Conjugate (PCV7)	1		Other:	3		
	2					
	3					

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		

* Must also check Chickenpox History box.

Chickenpox History
<input type="checkbox"/> Check the box if this person has a physician-certified reliable history of chickenpox. Reliable history may be based on: <ul style="list-style-type: none"> • physician interpretation of parent/guardian description of chickenpox • physical diagnosis of chickenpox, or • serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name (please print) _____

Date: / /

Signature: _____

Facility name: _____

PHYSICIAN STATEMENT FORM

Dear Physician: _____
(Child's Name)

is enrolled in an early childhood program licensed by the Department of Early Education and Care. The Department of Early Education and Care's regulations require at the time of admission a written statement from a physician as evidence of each child's annual physical examination, immunizations and lead screening in accordance with Department of Public Health's recommended schedules. A prompt response is appreciated.

Evidence of a physical exam is valid for one year from the date the child was examined and must be renewed annually thereafter.

IDENTIFICATION

Name of Child: _____ Date of Birth: _____

Address: _____ Phone # _____

Name of Parents: _____

Address: _____

Date of Examination of Child: _____

What is your opinion concerning the child's general health and appearance:

Has this child been screened for lead poisoning? Yes _____ No _____

If Yes, date screened: _____

Does this child have any disabilities or chronic medical problems (allergies, limited vision, etc.) which require special consideration or care by the child care provider? If so, please detail below:

Physician's Signature: _____

Date: _____ Comments: _____

Please return to Program: _____

THE COMMONWEALTH OF MASSACHUSETTS Department of Early
Education and Care

Small Group and Large Group Transportation Plan and Authorization

DISCOVER PRESCHOOL

CHILD'S NAME: _____

**MY CHILD WILL ARRIVE AT THE
PROGRAM:**

___ PARENT DROP OFF

___ SUPERVISED WALK

___ UNSUPERVISED WALK

___ PUBLIC/PRIVATE/VAN

___ PROGRAM BUS/VAN

___ CONTRACT/VAN

___ PRIVATE TRANS. ARRANGED BY
PARENT

___ OTHER

**MY CHILD WILL DEPART FROM THE
PROGRAM:**

___ PARENT PICK UP

___ SUPERVISED WALK

___ UNSUPERVISED WALK

___ PUBLIC/PRIVATE/VAN

___ PROGRAM BUS/VAN

___ CONTRACT/VAN

___ PRIVATE TRANS. ARRANGED BY
PARENT

___ OTHER

PARENT / GUARDIAN SIGNATURE _____ DATE _____

REFER TO DISMISSAL CONSENT FORM FOR RELEASE INFORMATION

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Child's Name: _____ Date of Birth: _____

I authorize staff in the child care program who are trained in the basics of first aid/CPR to give my child first aid/CPR when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to *the nearest medical care facility and/or to:* _____ , and to secure necessary medical treatment for my child.

Child's Physician Name: _____

Address: _____

Phone Number: _____

Child's Allergies: _____

Chronic Health Conditions: _____

Emergency Contacts (In order to be contacted)

Name _____

Address _____

Relationship to child _____

Home Phone _____ CellPhone _____

Do you give permission for child to be released to this person? Yes _____ No _____

Name _____

Address _____

Relationship to child _____

Home Phone _____ CellPhone _____

Do you give permission for child to be released to this person? Yes _____ No _____

Name _____

Address _____

Relationship to child _____

Home Phone _____ CellPhone _____

Do you give permission for child to be released to this person? Yes _____ No _____

Health Insurance Coverage _____	Policy # _____
Parent/Guardian Name: _____	Phone _____ Cell _____
Parent/Guardian Name: _____	Phone _____ Cell _____

Parent /Guardian Signature Date (valid for one year)

Discover Preschool

Dismissal Consent Form

*** Please add contact information for anyone (family friends, grandparents, aunts/uncles) who you think might possibly pick up your child from school.

I _____, hereby authorize the Discover Preschool to allow my child _____, to leave the Preschool with the following persons.

Name: _____

Address: _____

Phone #: _____

Relation to child: _____

Name: _____

Address: _____

Phone #: _____

Relation to child: _____

Name: _____

Address: _____

Phone #: _____

Relation to child: _____

Name: _____

Address: _____

Phone #: _____

Relation to child: _____

Name: _____

Address: _____

Phone #: _____

Relation to child: _____

Name: _____

Address: _____

Phone #: _____

Relation to child: _____

Parent/Guardian Signature: _____ Date _____

Changes to this form must be submitted in writing to the Director.

129 Reservation Rd Andover MA 01810 978-475-9706

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care
Discover Preschool

OFF SITE ACTIVITIES PERMISSION FORM

Section 1 - Program completes prior to parental consent

Program: DISCOVER PRESCHOOL

Name of Educator(s) responsible for child: DISCOVER TEACHERS

Name of off-site location and address: CHILDRENS GARDEN AT THE WEST PARISH CHURCH CEMETARY
SEPTEMBER 1, 2024 – JUNE 30, 2025

Date of off-site activity: _____ Time Leaving Program: _____ Time Returning to Program: _____

Method of Transportation: WALKING Fee associated with activity (if any): NONE

****NOTE**** Each child must carry on his/her person the name, address, and telephone number of staff or child care program whenever she/he is off the premises in care of the program.

Section 2 – Parent/Guardian completes prior to off-site activity

I give permission for my child to attend the above identified off-site activity

Child's Name: _____ Child's Date of Birth: _____

Parent's/Guardian's Name: _____ Phone Number: _____

I authorize child care program staff to secure necessary emergency medical treatment

Name of child's Physician, Address, phone number: _____

-

Child's allergies, health conditions, or Individual Health Plan: _____

-

Health Insurance Plan and Policy #: _____

Emergency Contact Name: _____ Contact #: _____

This form must accompany each child on the off-site activity